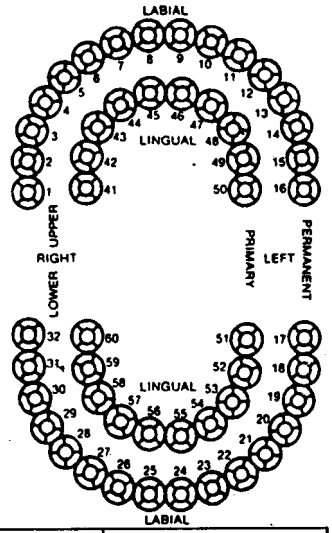
DENTAL SERVICE PRIOR AUTHORIZATION REQUEST
STATE OF MONTANA - SOCIAL and REHABILITATION SERVICES

FOR USE BY DENTISTS/DENTURISTS — PLEASE TYPE OR PRINT — FORM NO. MA-4PA

NAME & ADDRESS OF PROVIDER OF SERVICES	PROV. NO.	MAIL TO: MONTANA MEDICAID, DEPT. MA-4, P.O. BOX 8000, HELENA, MT 59604. TELEPHONE NUMBER 1-800-624-3958	
PATIENT: LAST NAME / FIRST / MIDDLE INITIAL	SEX M ☐ F ☐	DATE OF BIRTH MO. DAY YEAR	INDIVIDUAL NUMBER

	SURFACE NO.	TOOTH NUMBER	PROCEDURE NUMBER	DESCRIPTION OF SERVICE	EXPECTED DATE OF SERVICE	NO. SVCS.	CHARGES	APPROVAL YES	APPROVAL NO
1									
2									
3									
4									
5									
6									
7									
8									



CHARTING SYMBOLS	ABBREVIATIONS	
■ SURFACES TO BE - FILLED / TEETH TO BE EXTRACTED x MISSING TEETH	1 - MESIAL 2 - DISTAL 3 - OCCLUSAL 4 - LINGUAL 5 - INCISAL 6 - FACIAL	A - AMALGAM S - SILICATE P - PLASTIC C - CROWN G - GOLD

REASON FOR REQUESTED PROSTHESIS/SIGNS AND SYMPTOMS

PROSTHESIS (COMPLETE ONLY IF BEING REQUESTED)

DATE INSERTION OF LAST PROSTHESIS MO. DAY YEAR

TYPE OF LAST PROSTHESIS

DATE OF LAST EXTRACTION MO. DAY YEAR

TYPE OF PROSTHESIS REQUESTED

IS THIS A NEW PATIENT? ☐ YES

PLACE OF SERVICE IF OTHER THAN OFFICE _____

If the patient chooses to use a denturist, please complete this prescription block and give the form to the patient. The patient will take the form to the denturist who will complete the rest of it and submit it for approval.

R_x _____ Patient Name

_____ Signature of Prescribing Dentist

_____ Date

Authorization approves the medical necessity of the requested service only. It does not guarantee payment, nor does it guarantee that the amount billed will be the amount reimbursed. The recipient must be Medicaid Eligible on the date of service or date the prosthesis is received by the recipient. Authorization is valid for 180 days from the date of approval, if the patient is eligible on the date the services are rendered.

FOR ORTHODONTIA REQUESTS ONLY; TO BE COMPLETED BY REQUESTING DENTIST

NUMBER OF MONTHS OF SERVICE REQUESTED _____

ESTIMATED START DATE OF TREATMENT _____

CONSULTANT'S COMMENTS:

DATE: ____/____/____

ORTHODONTIA APPROVAL

MONTHLY ADJUSTMENT _____ MONTHS APPROVED

RETAINER SERVICE _____ MONTHS APPROVED

OTHER _____

_____ SIGNATURE OF PROVIDER REQUESTING AUTHORIZATION — DATE

_____ APPROVED BY — DATE

NOTE: This form will not be returned to you. You will receive notification through the MEDICAID R.A. or a letter.